MEDICAL CARE STATISTICS SECTION
Department of Health Services

Interim
MANAGED CARE ANNUAL STATISTICAL REPORT
Published August 2004

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal beneficiaries. It provides information on the number of persons enrolled in managed care, and a description of some of the demographic and eligibility characteristics of this population. It was decided that this year's "Interim" report would just highlight the Managed Care program, since enrollment and demographic data for the program has not changed significantly since last year.

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TABLE OF CONTENTS

Introduction

The Interim Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal eligibles. It also gives a description of the types of programs providing managed care services to Medi-Cal beneficiaries, the number of persons enrolled, and a description of some of the demographic and eligibility characteristics of this population.[1]

The Managed Care Annual Statistical Report does not present cost or utilization information for the Medi-Cal managed care population. Cost data for this population, as well as those in Fee-For-Service (FFS), are available in the Annual Statistical Report issued by this Section. Managed care utilization information is currently limited but will become available at a future date from the State Department of Health Services (DHS). Detailed information about dental managed care can be obtained from the DHS Payment Systems Division, Office of Medi-Cal Dental Services.

Please note the source for the enrollment and demographic charts and graphs in this report is the Monthly Medi-Cal Eligibles File, produced each month by the Department of Health Services. Eligibility data from this file for a previous month of eligibility was used to allow retroactive eligibles to be posted. In most cases, the month of eligibility for July 2003 was used from the file created late December 2003.

Other information related to Medi-Cal managed care is available on the DHS Medical Care Statistics Section (MCSS) website. The report entitled "Report on the Use of Medi-Cal Managed Care Encounter Data for Research Purposes," issued January 2002 (found under "Publications" on the MCSS website) reviews the quality and completeness of managed care encounter data. Current and historical counts of managed care beneficiaries by different variables are available in the "Beneficiary Data Files" section of the MCSS website.

[1] The terms "eligible," "beneficiary," and "enrollee" are used interchangeably within Medi-Cal. Each refers to a person who meets all requirements for receiving a Medi-Cal medical service or good (e.g., drugs, DME items) and is enrolled in the Medi-Cal program. These terms are differentiated from the term "user," who is a beneficiary actually receiving a service, drug, or DME item, etc.

Section 1, History and Description of Medi-Cal Managed Care

Prior to 1994, Medi-Cal had predominately used a FFS health care delivery system to provide care to its beneficiary population. Under this system, qualified providers render care or provide all covered services such as physician services, drugs, and durable medical equipment (DME) items to beneficiaries, then bill the State; upon adjudication of their claims for services, the providers are paid the Medi-Cal approved rate.

The State believed that converting to a managed care system based on preventive and primary care would provide better health care for Medi-Cal beneficiaries. Managed care is a planned, comprehensive approach to the provision of health care combining clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in an effective manner. Under managed care, individual providers are linked together into a system that formalizes the often-informal provider relationships that exist under FFS and brings them together under a single entity, the managed care plan. The plan manages the links and is accountable for performance and outcomes. Managed care's emphasis on access to primary care is intended to increase utilization of clinical preventive services and thus reduce both preventable hospitalizations and the unnecessary use of emergency rooms. In turn, this enables the plan to reallocate its resources to promote preventive and primary care for its members.

Section 1.1, History of Medi-Cal Managed Care

The State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972 Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category. In June 1983, a new type of managed care program, the County Organized Health System (COHS), began covering Medi-Cal beneficiaries when the Monterey Health Initiative became operational. This program stressed case management and utilization control in the delivery of health services to Medi-Cal eligibles. A few months later, in September 1983, the Santa Barbara Health Initiative also began operating a COHS. Both were similar in that almost all beneficiaries in the county were mandated to join the plan. Whereas the Monterey program stressed local control Primary Care Case Management (PCCM), Santa Barbara stressed centralized utilization control. The Monterey COHS ceased operations in July 1985 and has since been replaced with the Central Coast Alliance for Health, which covers both Monterey and Santa Cruz counties. A third COHS, the Health Plan of San Mateo, began operations in December 1987.

In August 1984, a third Medi-Cal managed care program began operation, the PCCM program. Like the PHP program, enrollment in PCCM plans was voluntary. The PCCMs were responsible for outpatient services only. Inpatient services for PCCM enrollees were delivered through the FFS program. The PCCM stressed assignment of

a personal physician to each beneficiary in the plan, and that physician authorized virtually all other services delivered by the PCCM plan.

State legislation in 1991 and 1992 enabled a substantial expansion of Medi-Cal managed care, primarily for AFDC-linked eligibles.[2] Pursuant to this legislation, the Department of Health Services (DHS) started the process of developing and implementing a Geographic Managed Care (GMC) program in two counties, a Two-Plan Model program in twelve counties, and the COHS program in three additional counties. (See Appendix, Table A.1 for a list of the aid categories each of these plans cover.) In addition, a Special Project referred to as the Medi-Cal Fee-For-Service Managed Care Program (FFS-MC) began operations in the counties of Sonoma and Placer in March and October 1997, respectively.

The 1991 managed care legislation was significant in that prior to 1991 in a county in which Medi-Cal managed care plan enrollment was available, beneficiaries who did not choose between FFS and a plan were defaulted into FFS. With the 1991 legislation, the state was allowed under specific circumstances to direct the defaults into managed care.

Section 1.2, Description of Medi-Cal Managed Care

Before 1994, there were three managed care programs providing medical care to the Medi-Cal population, the PHP program, the PCCM program, and the COHS program. From 1994 forward, two more programs were developed and implemented, the GMC program and the Two-Plan Model program. In 1995 and 1996, three additional counties formed COHS organizations. Currently, there are four managed care programs enrolling Medi-Cal eligibles: PHPs (full capitation, voluntary), COHSs (most aid categories, mandatory), GMC plans (Managed Care Family aid categories, mandatory) and Two-Plan Model plans (Managed Care Family aid categories, mandatory). There is only one PCCM program enrolling Medi-Cal eligibles as of June 2003. The following describes each of these programs.

Prepaid Health Plan

The State Waxman-Duffy Act authorized Health Maintenance Organization (HMO) contracting in the Medi-Cal Program and referred to such plans as PHPs. In California, the PHP contracting program was established as an alternative to FFS. The intent of the program was to provide the Managed Care Family aid categories Medi-Cal beneficiaries

[2] Other terms and programs, pursuant to recent Federal and State legislation, are replacing the term Aid to Families with Dependent Children (AFDC). For example, some persons formerly on AFDC are now on California's CalWorks' (made possible by Section l93lb of Title XIX of the Social Security Act), which implements the "Federal Temporary Assistance to Needy Families" (TANF) program. Other formerly AFDC eligibles are referred to as eligible under Section l93lb of Title XIX of the Social Security Act. What was formerly referred to as AFDC is referred to in this report as "Managed Care Family" aid categories.

who enrolled to have access to health care generally available in the public sector. PHPs are required to provide, on a capitated, at-risk basis, all basic Medi-Cal covered benefits, excluding such specified treatments as major organ transplants, chronic renal dialysis and long term care. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classifications.) In addition, PHPs provide case management, preventive and health maintenance services. As managed care contractors, PHPs have other requirements not found in FFS, such as quality of care management, membership services, and member grievance procedures. DHS administers the contracts with the PHP contractors and the Department of Managed Health Care oversees their operations as commercial health plans under the Knox-Keene Act. As of June 2003, beneficiaries in PHPs comprise 0.02% of all Medi-Cal beneficiaries, or about 1,100 members per month.

Primary Care Case Management

The PCCM program is a managed care model that covers outpatient, physician, and some other outpatient services. PCCMs exclude inpatient services and some outpatient services from the scope of benefits provided under their capitated contracts. Under PCCM arrangements, primary care providers contract with DHS as managed care plans to provide and assume risk for primary care and specialty physicians' services as well as selected outpatient preventive and treatment services. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classifications.) PCCM contractors are required to case manage all services provided to their enrollees. Contractors participate in program savings through savings-sharing agreements with DHS. Shared savings must be produced by the PCCM's effective case management of services for which the PCCM is not at risk, the most significant of which is inpatient hospital care.

PCCM contracts operate under DHS review and oversight. Although PCCMs have not been directly subject to either the Knox-Keene or Waxman-Duffy Prepaid Health Plan Act, many of the relevant requirements are reflected in these contracts. Due to the implementation of the mandatory managed care programs, only one PCCM is in operation and enrolling Medi-Cal beneficiaries, AIDS/Positive Healthcare Foundation in Los Angeles county. As of June 2003, beneficiaries in this PCCM comprise 0.01% of all Medi-Cal beneficiaries, or about 780 members per month.

Geographic Managed Care

Sacramento County was selected for the development of a GMC program in early 1992, and the program began enrolling in April 1994. Initially, under Sacramento GMC, DHS contracted with seven managed care health plans for medical services and four dental care plans for dental services. Five of the seven plans were fully-capitated PHP plans and two were PCCMs.

The California Medical Assistance Commission negotiates capitation rates on behalf of DHS with each plan; rates are kept confidential. The mandatory aid category groups are: Managed Care Family aid categories, medically needy with no share of cost, medically indigent adult (confirmed pregnancy), medically indigent children, and percent-of-poverty children. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classification.) Medi-Cal beneficiaries allowed to join voluntarily include those who are in a Supplemental Security Income (SSI) or foster child aid category or who otherwise meet certain medical exemption criteria. Beneficiaries enrolled with a commercial or Medicare HMO are not allowed to enroll. In addition, eligibles in a mandatory aid category will not be enrolled in a plan during the months of retroactive eligibility or for the two months while they decide into which plan they want to enroll.

DHS received waivers of federal requirements for freedom of choice that permitted provision of Medi-Cal benefits to this population exclusively through GMC managed care plans. State legislation in 1994 permitted a second GMC program, referred to as "Healthy San Diego," to be formed in San Diego county. Enrollment began in mid-1998.

Under GMC, covered beneficiaries are informed about the available managed care plans and then are asked to select a plan. Beneficiaries are assisted in the selection process through the involvement of a Health Care Options (HCO) contractor, who provides them a presentation and explanatory materials about each of the plans. If a beneficiary does not select a plan, he/she is assigned to one.

Currently, there are five comprehensive plans in Sacramento county and seven in San Diego county that cover inpatient and all other medical services. DHS directly contracts with each of these GMC plans. As of June 2003, beneficiaries in GMCs comprise 5.3% of all Medi-Cal beneficiaries, or about 337,830 members per month.

County Organized Health Systems

Under the COHS model, a county board of supervisors to contract with the Medi-Cal program creates a local agency, with representation from providers, beneficiaries, local government, and other interested parties. Operating under federal Medicaid freedom of choice and other waivers, the COHS administers a capitated, comprehensive, case managed health care delivery system. They are responsible for utilization control and claims administration, and must provide most Medi-Cal covered health care services. COHSs are health insuring organizations which manage and pay for services but do not directly provide care. Virtually all Medi-Cal beneficiaries with legal residency in the county must belong to the COHS. (Medi-Cal beneficiaries who are in recently established aid categories may not be covered due to a lack of historical data upon which to establish capitation rates.) Beneficiaries are given a wide choice of providers but do not have the option of obtaining Medi-Cal services under the traditional FFS system except for those services excluded from coverage, e.g., long term care (one plan only). Like the GMC program, the California Medical Assistance Commission negotiates capitation rates for each plan, except the Santa Barbara Health Initiative; these rates are also kept confidential.

Three COHSs operated in the 1980's in the counties of Monterey, Santa Barbara, and San Mateo. Monterey ceased operations in 1985. Enabling State legislation and federal HCFA waiver approvals later permitted three additional counties to form COHSs. The Solano Partnership Health Plan began operations in May 1994 and became Partnership HealthPlan of California in March 1998, when Napa county was added. In October 1995, the California Orange Prevention and Treatment Integrated Medical Assistance Plan (CalOPTIMA) started enrolling Medical beneficiaries. In January 1996, the Santa Cruz County Health Options began operations; when Monterey county joined Santa Cruz in October 1999, the plan changed its name to Central Coast Alliance for Health. Yolo county joined the Partnership HealthPlan of California in March 2001.

COHSs currently exist in Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano and Yolo counties. As of June 2003, beneficiaries in COHSs comprise 8.5% of all Medi-Cal beneficiaries, or about 546,010 members per month.

Two-Plan Model

A plan for a new type of Medi-Cal managed care program was developed by DHS and a report was issued March 31, 1993 entitled Expanding Medi-Cal Managed Care. Under this program, two HMO plans operate in each of the selected counties. One is operated under the auspices of the county government or a community based entity, e.g., an independent health commission; the other is a commercial HMO selected by DHS through competitive bid. The two plans are directly monitored by DHS and have the same contract requirements. The publicly sponsored plan is referred to as the local initiative (LI), and the private HMO as the commercial plan (CP). It was envisioned that the LI would provide a means for hospitals, clinics, and physicians who traditionally cared for Medi-Cal beneficiaries under FFS, as well as the safety net providers who provide care to both Medi-Cal beneficiaries and other medically indigent persons, to continue providing these services under managed care. In the case of hospitals, this arrangement helps support receipt of federal disproportionate share hospital funds. Contract provisions also promote use of cultural and linguistic services for those beneficiaries needing them. Both the LI and CP plans provide full medical services, including inpatient, and must be Knox-Keene licensed. Contract rates are established by DHS.

The mandatory aid category groups are: Managed Care Family aid categories, medically needy with no share of cost, medically indigent adult (confirmed pregnancy), medically indigent children, and percent poverty children. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classification.) Those allowed to join voluntarily include those who are in an SSI or foster child aid category or who meet certain medical exemption criteria.

The counties selected by DHS for the Two-Plan Model initially included Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Subsequently, San Diego was legislatively chosen to implement the GMC program (see above). Fresno chose not to implement a local initiative, thereby resulting in DHS selecting a second commercial plan for that county. Health Net is scheduled to start up a commercial plan in Stanislaus County in fall of 2004. As of June 2003, beneficiaries in Two-Plan model plans comprise 37.7% of all Medi-Cal beneficiaries, or about 2,419,467 members per month.

Special Projects

These managed care programs strive to promote improved health status and to avoid non-duplicative or otherwise unnecessary costs. Two types of special projects currently implemented by DHS are:

Medical Case Management of Populations with Special Health Care Needs -- DHS has established other programs to manage high-cost Medi-Cal beneficiaries within the FFS environment. Under this program, DHS develops and conducts pilot projects under which these populations receive medical case management. Examples include those with AIDS and the elderly at risk of entering long-term care, e.g., On Lok and Scan Health plans

Fee-For-Service Managed Care (FFS-MC) -- DHS established fee-for-service, "gatekeeper model" managed care programs in Sonoma and Placer Counties, starting March and October 1997, respectively. This program paid the contracted local government a fee per eligible per month for: 1) establishing a primary care physician network from which beneficiaries selected or were assigned to a personal physician; and 2) case managing the services received by the Medi-Cal beneficiaries, thereby improving coordination of care. The FFS-MC waiver program was terminated June 30, 2003. Beneficiaries were rolled into straight Fee-for-Service Medi-Cal.

Scope of Services Covered by Managed Care

The scope of services covered by Medi-Cal managed care health plans is determined by their contract with DHS. Comprehensive plans typically cover inpatient care, limited skilled nursing services, and most outpatient services. Exceptions may vary from plan to plan and between managed care models. Plans are required to provide all medically necessary care, but may restrict such coverage to no more than what Medi-Cal would cover or may expand the coverage provided. Plans do not cover services such as Psychiatric and AIDS drugs. Carved out services are listed in the EDS (FFS) Provider Manuals, available at http://www.medi-cal.ca.gov/, in Appendix A of The Researcher's Guide To Medi-Cal Data, available at http://www.dhs.ca.gov/mcss/GeneralInfo/generalinformation.htm, or can be obtained by calling the DHS Medi-Cal Managed Care Division.

Section 2, Enrollment Statistics for Medi-Cal Managed Care

Enrollment in Medi-Cal managed care plans rose sharply in the mid-1990's and currently represents 52% of the total Medi-Cal eligibles. Table 2.1, Medi-Cal Eligibles by Program FFS vs. Managed Care Programs, shows how the relative number of beneficiaries in the various managed care plans as well as FFS has remained unchanged since early 2000, but all numbers have increased as the total Medi-Cal population has grown.

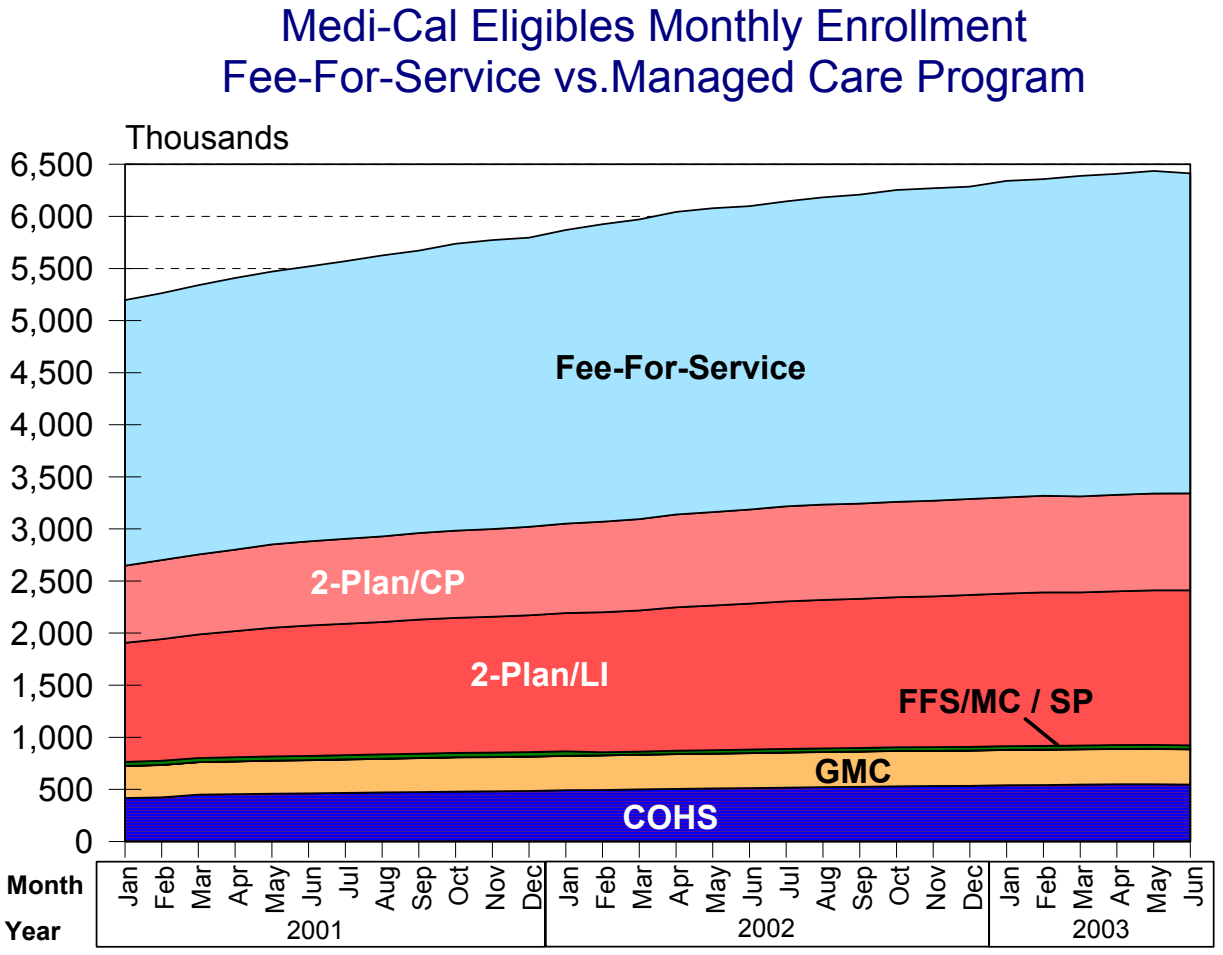
Medi-Cal managed care is in twenty-four of California's fifty-eight counties, excluding the small Kaiser PHP in Marin County. Tables 2.2 and 2.3, Medi-Cal Managed Care Plans by County, list the different plans by name and county of service along with other pertinent information, such as current enrollment figures.

Analyses of the composition of the managed care plans versus FFS in terms of mandatory Medi-Cal aid code categories follow in Tables 2.4 through 2.6. Table 2.4, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties, provides aggregated counts for the Two-Plan and GMC versus the COHS counties, and Table 2.5, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties, provide these breakouts by county. Lastly, Table 2.6, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles in GMC and Two-Plan Model Counties Only, illustrate how, in most cases, 80 to 90% of the mandatory aid code category beneficiaries actually end up in one of these managed care plans. The narrative for this table lists nine of the most common reasons for this occurrence.

Table 2.1, Medi-Cal Eligibles by Program – FFS vs. Managed Care Programs

The following graph shows the monthly enrollment (January 2000 forward) in Medi-Cal for medical FFS and managed care plans. Each type of managed care program is shown separately. Total June 2003 enrollment was: FFS – 3,070,798; COHS – 546,010; GMC – 337,834; Two-Plan/Local Initiative – 1,489,692; Two-Plan/Commercial Plan – 929,775; FFS/MC – 32,073; SP – 4,249; PHP – 1,097; PCCM – 782.

Source: July 2003 month of eligibility Medi-Cal Eligibles File, using a six-month lag.
FFS/MCN eligible counts source is the Monthly Enrollment Report Provided by the Managed Care Fiscal Monitoring Unit.



Note: By June of 2003 the PHP/PCCM population represent less than one-tenth of one percent (0.029%) of the total Medi-Cal population.

Table 2.2, Medi-Cal Managed Care Plans by County
Prepared by the California Department of Health Services

The following tables show Medi-Cal managed care plans by county (Table 2.2) and by plan then county (Table 2.3). The managed care programs included here are: COHS, FFS-MC, GMC, and Two-Plan Model. Excluded are PHP, PCCM, and special projects (e.g., AIDS, SCAN).

Table 2.2, Medi-Cal Managed Care Plans by County

County	Program	LI/ CP*	Plan Name	Start Date	Enrollment** as of July 2003
Alameda	2-PLAN	LI	Alameda Alliance for Health	1/96	74,015
		CP	Blue Cross of California	7/96	28,184
Contra Costa	2-PLAN	LI	Contra Costa Health Plan	2/97	41,560
		CP	Blue Cross of California	6/98	7,462
Fresno	2-PLAN	CP	Health Net	1/97	28,952
		CP	Blue Cross of California	11/96	128,767
Kern	2-PLAN	LI	Kern Health Systems	7/96	69,789
		CP	Blue Cross of California	9/96	35,309
Los Angeles	2-PLAN	LI	LA Care Health Plan	4/97	819,247
		CP	Health Net	7/97	531,540
Monterey	COHS		Central Coast Alliance For Health	10/99	55,477
Napa	COHS		Partnership Health Plan of California	3/98	9,887
Orange	COHS		CalOPTIMA	10/95	287,983
Placer ***	FFS/MC		Placer County Managed Care Network	10/97	0
Riverside	2-PLAN	LI	Inland Empire Health Plan	9/96	101,907
		CP	Molina Healthcare	3/98	39,525
Sacramento	GMC		Blue Cross of California	4/94	76,078
			Health Net	5/96	30,497
			Kaiser Foundation Health Plan	4/94	20,000
			Western Health Advantage	5/97	15,690
			Molina Healthcare	2/00	20,108

Table 2.2, Medi-Cal Managed Care Plans by County (continued)

Prepared by the California Department of Health Services

County	Program	LI/ CP*	Plan Name	Start Date	Enrollment** as of July 2003
San Bernardino	2-PLAN	LI	Inland Empire Health Plan	9/96	130,097
		CP	Molina Healthcare	3/98	52,193
San Diego**	GMC		Blue Cross of California	7/98	15,737
			Community Health Group	7/98	65,540
			Health Net	7/98	8,903
			Kaiser Foundation	7/98	8,906
			Sharp Health Plan	7/98	50,016
			UCSD Healthcare	7/98	13,336
			Universal Care	7/98	12,850
San Francisco	2-PLAN	LI	San Francisco Health Plan	1/97	28,896
		CP	Blue Cross of California	7/96	14,173
San Joaquin	2-PLAN	LI	Health Plan of San Joaquin	2/96	56,394
		CP	Blue Cross of California	1/97	20,042
San Mateo	COHS		Health Plan of San Mateo	12/87	46,408
Santa Barbara	COHS		Santa Barbara Health Initiative	9/83	51,306
Santa Clara	2-PLAN	LI	Santa Clara Family Health Plan	2/97	67,759
		CP	Blue Cross of California	10/96	25,653
Santa Cruz	COHS		Central Coast Alliance for Health	1/96	26,621
Solano	COHS		Partnership Health Plan of California	5/94	46,093
Sonoma *	FFS/MC		Sonoma Partners for Health Managed Care	3/97	0
Stanislaus	2-PLAN	LI	Blue Cross of California/SLI	10/97	39,320
Tulare	2-PLAN	LI	Blue Cross of California	3/99	60,905
		CP	Health Net	2/99	15,809
Yolo	COHS		Partnership Health Plan of California	3/01	23,123

* "LI" stands for Local Initiative; "CP" stands for Commercial Plan.

** Source for number of eligibles for all plans except FFS/MC is the Monthly Medi-Cal Eligibility File.

*** Source for FFS/MC eligible counts is the Monthly Enrollment Report provided by the Managed Care Fiscal Monitoring Unit. This program was terminated June 30, 2003.

**** The official name for the San Diego GMC is "Healthy San Diego".

Table 2.3, Medi-Cal Managed Care Plans by County
Prepared by the California Department of Health Services

Plan Name	Program	LI/CP*	County	Enrollment** as of July 2003
Alameda Alliance for Health	2-PLAN	LI	**Alameda**	**74,015**
Blue Cross of California			**TOTAL**	**451,630**
	2-PLAN	CP	**Alameda**	28,184
	2-PLAN	CP	**Contra Costa**	7,462
	2-PLAN	CP	**Fresno**	128,767
	2-PLAN	CP	**Kern**	35,309
	GMC		**Sacramento**	76,078
	GMC		**San Diego****	15,737
	2-PLAN	CP	**San Francisco**	14,173
	2-PLAN	CP	**San Joaquin**	20,042
	2-PLAN	CP	**Santa Clara**	25,653
	2-PLAN	LI	**Stanislaus**	39,320
	2-PLAN	LI	**Tulare**	60,905
CalOPTIMA	COHS		**Orange**	**287,983**
Central Coast Alliance For Health			**TOTAL**	**82,098**
	COHS		**Monterey**	55,477
	COHS		**Santa Cruz**	26,621
Community Health Group	GMC		**San Diego****	65,540
Contra Costa Health Plan	2-PLAN	LI	**Contra Costa**	41,560
Health Net			**TOTAL**	**615,701**
	2-PLAN	CP	**Fresno**	28,952
	2-PLAN	CP	**Los Angeles**	531,540
	GMC		**Sacramento**	30,497
	GMC		**San Diego****	8,903
	2-PLAN	CP	**Tulare**	15,809
Health Plan of San Joaquin	2-PLAN	LI	**San Joaquin**	**56,394**
Health Plan of San Mateo	COHS		**San Mateo**	**46,408**
Inland Empire Health Plan			**TOTAL**	**232,004**
	2-PLAN	LI	**Riverside**	101,907
	2-PLAN	LI	**San Bernardino**	130,097

Table 2.3, Medi-Cal Managed Care Plans by County (continued)

Prepared by the California Department of Health Services

Plan Name	Program	LI/CP*	County	Enrollment** as of July 2003
Kaiser Foundation Health Plan		**TOTAL**		**74,015**
	GMC		**Sacramento**	8,906
	GMC		**San Diego****	20,000
Kern Health Systems	2-PLAN	LI	**Kern**	**69,789**
LA Care Health Plan	2-PLAN	LI	**Los Angeles**	**819,247**
Molina Healthcare		**TOTAL**		**111,826**
	2-PLAN	CP	**Riverside**	39,525
	GMC		**Sacramento**	20,108
	2-PLAN	CP	**San Bernardino**	52,193
Partnership Health Plan of California		**TOTAL**		**79,103**
	COHS		**Napa**	9,887
	COHS		**Solano**	46,093
	COHS		**Yolo**	23,123
Placer County Managed Care Network	FFS/MC		**Placer*****	**0**
San Francisco Health Plan	2-PLAN	LI	**San Francisco**	**28,896**
Santa Barbara Health Initiative	COHS		**Santa Barbara**	**51,306**
Santa Clara Family Health Plan	2-PLAN	LI	**Santa Clara**	**67,759**
Sharp Health Plan	GMC		**San Diego****	**50,016**
Sonoma Partners for Health Managed Care	FFS/MC		**Sonoma*****	**0**
UCSD Healthcare	GMC		**San Diego****	**13,336**
Universal Care	GMC		**San Diego****	**12,850**
Western Health Advantage	GMC		**Sacramento**	**15,690**

* "LI" stands for Local Initiative; "CP" stands for Commercial Plan.

** Source for number of eligibles for all plans except FFS/MC is the Monthly Medi-Cal Eligibility File.

*** Source for FFS/MC eligible counts is the Monthly Enrollment Report provided by the Managed Care Fiscal Monitoring Unit. This program was terminated June 30, 2003.

**** The official name for the San Diego GMC is "Healthy San Diego".

Table 2.4, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties

The following pie charts show the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. FFS and mandatory vs. voluntary/other aid category group, for counties implemented to managed care as of July 2003. (See Table 1.7 for a list of these counties.) As this indicates, the percent of those in managed care is 53.8% (2.6% + 51.2%) for the Two-Plan and GMC counties and 82.5% (0.1% + 82.4%) for the COHS counties for all aid categories. The COHS mandatory managed care population will always be larger than that of the Two-Plan and GMC models since virtually all Medi-Cal beneficiaries in the county must belong to the COHS. For a more detailed description of the COHS plans, please see Section 1.2, Description of Medi-Cal Managed Care, County Organized Health Systems of this report. (See Appendix, Table A.1 for definitions of the aid category groupings.)

As discussed in Section 1, Medi-Cal beneficiaries in managed care counties receive their medical services predominately through fee-for-service (FFS) or through a managed care plan. For counties for which there is a COHS model, or for counties for which there is at least two GMC model or Two-Plan model plans (or Stanislaus), beneficiaries either must choose one plan to enroll in or are mandated into one if they are in a mandatory aid code (exceptions exist; see Table 2.6). (See Appendix Table A.1 for a list of aid codes by category.) Beneficiaries in a voluntary aid code, applicable to Two-Plan and GMC model counties only, may choose to enroll in a managed care, but are not mandated into one if they do not choose. Beneficiaries in an "other" aid code may not enroll in a managed care plan.

In general, from an eligibility standpoint, these various categories can be described as follows:

- COHS, Other: Medically Needy/Medically Indigent; Undocumented Aliens
- COHS, Mandatory: All other aid codes.

- Two-Plan and GMC, Other: Share of Cost; Undocumented Aliens; Long Term Care.
- Two-Plan and GMC, Voluntary: Aged, Blind and Disabled.
- Two-Plan and GMC, Mandatory: All other aid codes.

The tables below show the distribution of beneficiaries for the COHS and the Two-Plan/GMC counties for the categories:

<u>Two-Plan/GMC Counties</u>

- Beneficiaries in mandatory aid code enrolled in managed care ("Managed Care - Mandatory").
- Beneficiaries in voluntary or "other" aid code enrolled in managed care ("Managed Care - Voluntary/Other").
- Beneficiaries in mandatory aid code enrolled in FFS ("FFS - Mandatory").
- Beneficiaries in voluntary or "other" aid code enrolled in FFS ("FFS - Voluntary/Other").

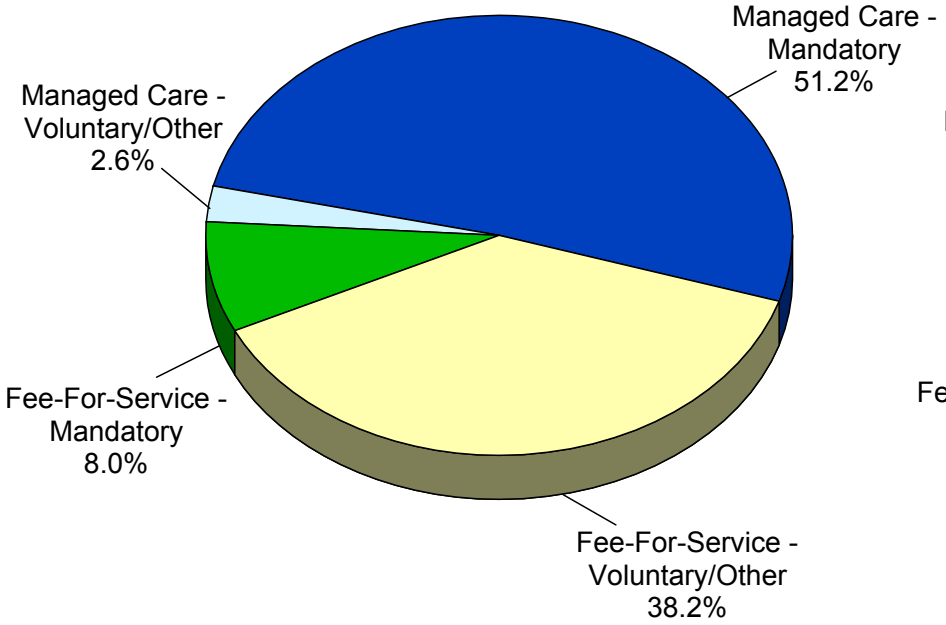
Table 2.4, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties (continued)

COHS Counties

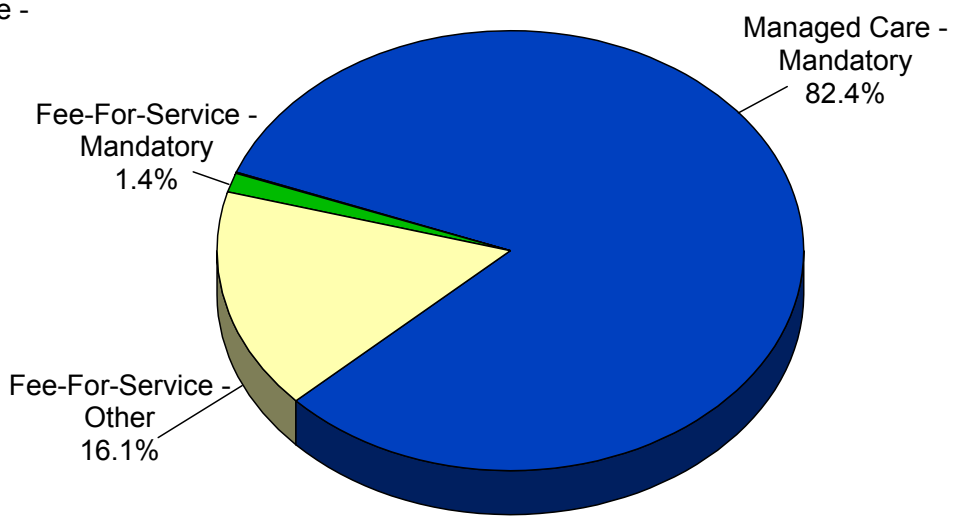
- Beneficiaries in mandatory aid code enrolled in managed care ("Managed Care - Mandatory").
- Beneficiaries in voluntary or "other" aid code enrolled in managed care ("Managed Care - Other").
- Beneficiaries in mandatory aid code enrolled in FFS ("FFS - Mandatory").
- Beneficiaries in voluntary or "other" aid code enrolled in FFS ("FFS - Other").

Source of these data is the July 2003 month of eligibility Medi-Cal Eligibles File, using a six-month lag.

Two-Plan and GMC Counties
Eligibles in Fee-For-Service and Managed Care
Percent Mandatory vs. Voluntary/Other Aid Group



COHS Counties
Eligibles in Fee-For-Service and Managed Care
Percent Mandatory vs. Other* Aid Group

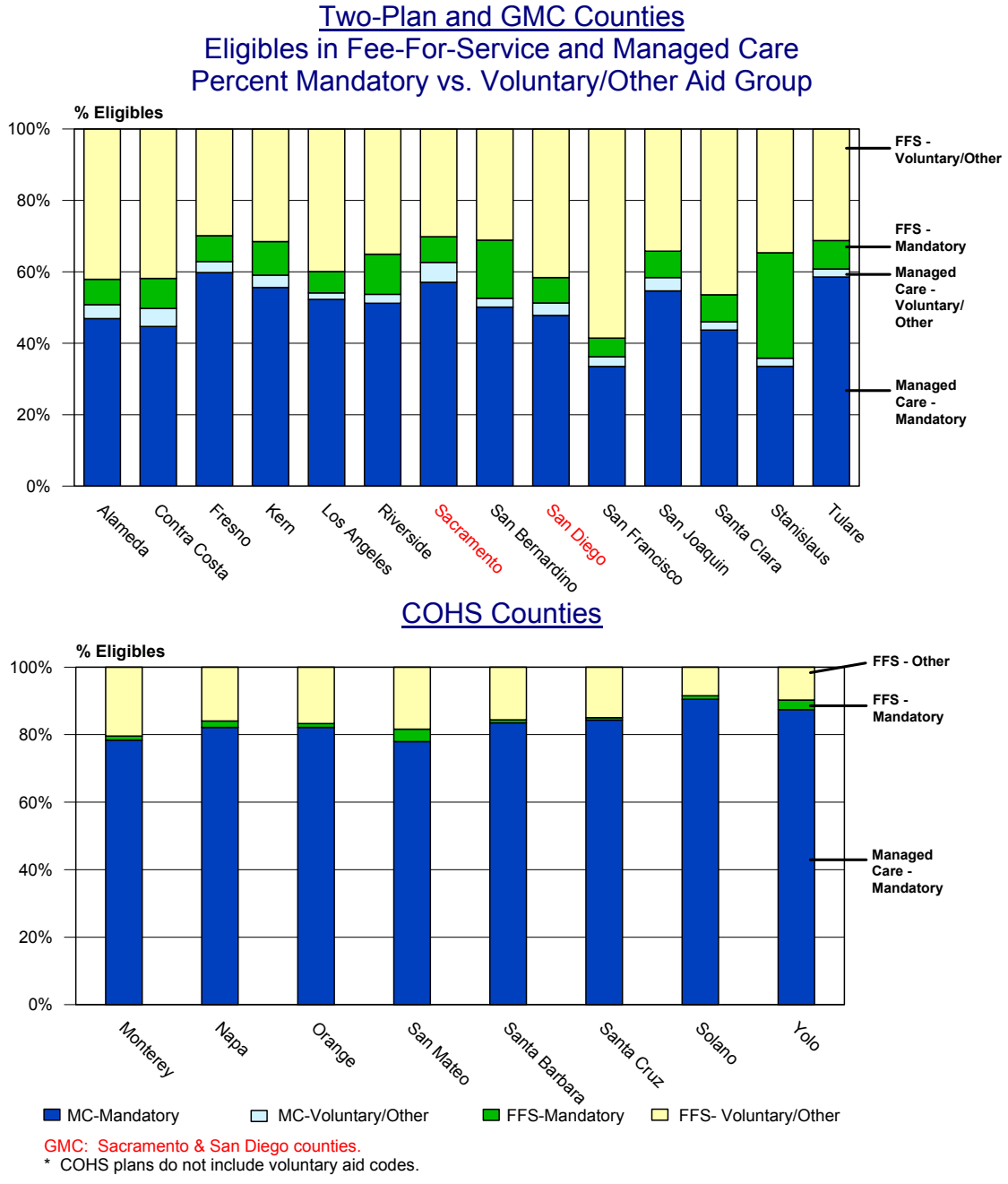


* COHS plans do not include voluntary aid codes.
The Other Aid Group for Managed Care eligibles is 0.1%

Table 2.5, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties

The following bar chart provides the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. FFS, and mandatory vs. voluntary/other aid category group (four aid categories in all), for counties implemented to managed care as of July 2003. The chart shows that in most counties over 40% of these beneficiaries are in managed care. The commercial plan in Stanislaus County ceased operations in March 2000; as a result, beneficiaries in mandatory aid codes could elect to enroll into the remaining local initiative or FFS. If a beneficiary did not make a selection they were defaulted into the local initiative. Health Net is scheduled to start up a new commercial plan in Stanislaus County in fall of 2004. (See Appendix, Table A.1 for definitions of the aid category groupings.)

Source of these data is the July 2003 month of eligibility Medi-Cal Eligibles File, using a six-month lag.



GMC: Sacramento & San Diego counties.
* COHS plans do not include voluntary aid codes.

Table 2.6, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles in GMC and Two-Plan Model Counties Only

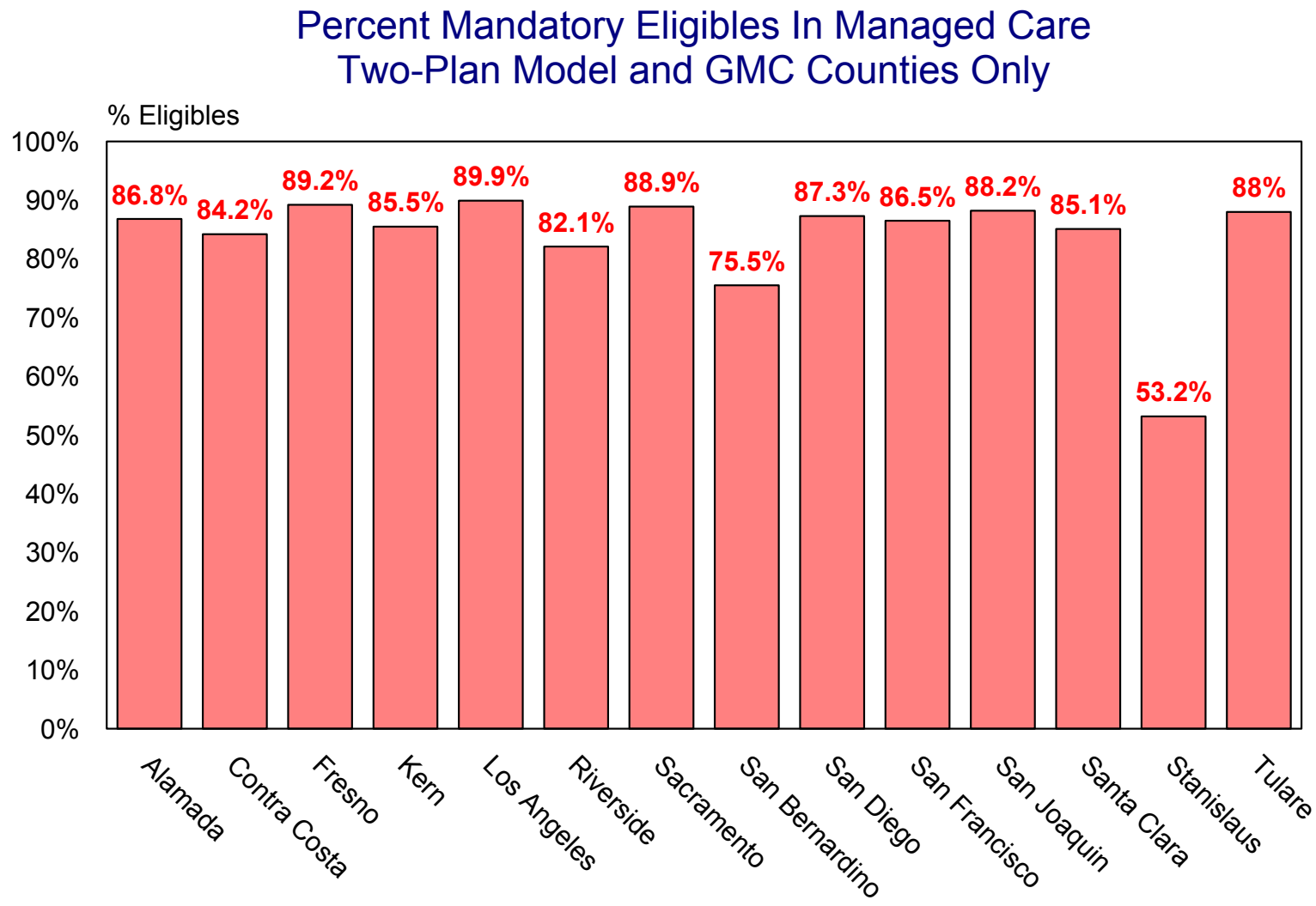
Of those eligibles in a mandatory aid category, the following chart shows the percent of those actually enrolled in a Two-Plan model or GMC managed care plan by county. Overall, there has been no significant change since July 2002 (see the Managed Care Annual Statistical Report published June 2003). The average number of mandatory managed care beneficiaries for Two-Plan and GMC model counties (excluding Stanislaus County, see item nine below) is 195,247 and the average percent of mandatory managed care beneficiaries for Two-Plan and GMC model counties is 85.9. Eight (Alamada, Fresno, Los Angeles, Sacramento, San Diego, San Francisco, San Joaquin, and Tulare) of the thirteen counties have a percent of beneficiaries in a mandatory aid category enrolled in managed care greater than 85.9.

The percent of beneficiaries in a mandatory aid category enrolled in managed care is always less than 100%. Not every beneficiary in a mandatory aid category will end up in a managed care plan. Reasons for this include:

1) managed care implementation is still in process;
2) the beneficiary received Medi-Cal eligibility retroactively (that is, between the start of the eligibility month and some months later);
3) the beneficiary has other health coverage (usually CHAMPUS, Medicare HMO, Kaiser, or some PHP/HMO and Exclusive Provider Option coverage) that excludes them from enrolling in a plan;
4) the beneficiary just became eligible for Medi-Cal in a particular county, and is still in the process of selecting a plan or will be defaulted into one;
5) the beneficiary lives in an exempted zip code;
6) the beneficiary has a medical exemption granted by the DHS (for a complete list of these exemptions, contact the DHS Medi-Cal Managed Care Division);
7) a person born to a mother on managed care is covered under FFS the month of delivery and the following month, and then is put into managed care only after the parents(s)/legal guardian(s) successfully completes the Medi-Cal enrollment process (usually three to six months after birth);
8) a person switches from a non-mandatory to a mandatory aid code and is still in the process of selecting a plan;
9) in the case of Stanislaus county, the commercial plan ceased operations in March 2000; as a result, beneficiaries in mandatory aid codes could elect to enroll into the remaining local initiative or FFS. If a beneficiary did not make a selection they were defaulted into the local initiative.

Table 2.6, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles in GMC and Two-Plan Model Counties Only (continued)

Source of these data is the July 2003 month of eligibility Medi-Cal Eligibles File, using a six-month lag.



Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status

Prepared by the California Department of Health Services

The following table provides a list of aid categories that are considered mandatory (M), vs. voluntary (V), vs. other (o) [can't join] for each plan model. (Note: This table was current as of May 2003. For a current table, contact the DHS Medi-Cal Managed Care Division.)

	COHS			GMC	Two-Plan	FFS/MCN*	PHP/ PCCM
Aid Cat.	San Mateo & Solano	Yolo	Monterey, Napa, Orange, Santa Barbara, & Santa Cruz	Sacramento & San Diego			
01	M	M	M	M	M	V	V
02	M	M	M	M	M	V	V
03	M	M	M	V	V	V	V
04	M	M	M	V	V	V	V
08	M	M	M	M	M	V	V
0A	M	M	M	M	M	V	V
0M	M	M	M	V	V	V	V
0N	M	M	M	V	V	V	V
0P	M	M	M	V	V	V	V
0R	M	M	M	V	V	V	V
0T	M	M	M	V	V	V	V
0U	M	M	M	V	V	V	V
10	M	M	M	V	V	V	V
13	M	M	M	o	o	o	o
14	M	M	M	V	V	V	V
16	M	M	M	V	V	V	V
17	M	M	M	o	o	o	o
18	M	M	M	V	V	V	V
1E	M	M	M	V	V	V	V
1H	M	M	M	V	V	V	V
1X	M	M	M	V	V	V	V
1Y	M	M	M	V	V	V	V
20	M	M	M	V	V	V	V
23	M	M	M	o	o	o	o
24	M	M	M	V	V	V	V
26	M	M	M	V	V	V	V
27	M	M	M	o	o	o	o
28	M	M	M	V	V	V	V
2E	M	M	M	V	V	V	V
30	M	M	M	M	M	M	V
32	M	M	M	M	M	M	V
33	M	M	M	M	M	M	V
34	M	M	M	M	M	M	V
35	M	M	M	M	M	M	V
36	M	M	M	V	V	V	V
37	M	M	M	o	o	o	o
38	M	M	M	M	M	M	V
39	M	M	M	M	M	M	V
3A	M	M	M	M	M	M	V
3C	M	M	M	M	M	M	V
3E	M	M	M	M	M	M	V
3G	M	M	M	M	M	M	V
3H	M	M	M	M	M	M	V
3L	M	M	M	M	M	M	V
3M	M	M	M	M	M	M	V
3N	M	M	M	M	M	M	V
3P	M	M	M	M	M	M	V
3R	M	M	M	M	M	M	V
3U	M	M	M	M	M	M	V
3W	M	M	M	M	M	M	V

Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status

	COHS			GMC	Two-Plan	FFS/MCN*	PHP/ PCCM
Aid Cat.	San Mateo & Solano	Yolo	Monterey, Napa, Orange, Santa Barbara, & Santa Cruz	Sacramento & San Diego			
40	M	M	M	V	V	V	V
42	M	M	M	V	V	V	V
45	M	M	M	V	V	V	V
47	M	M	M	M	M	M	V
4A	M	M	M	V	V	o	V
4C	M	M	M	o	V	V	V
4F	M	M	M	V	V	V	V
4G	M	M	M	V	V	V	V
4K	M	M	M	V	V	V	V
4M	M	M	M	V	V	V	V
53	M	M	M	o	o	o	o
54	M	M	M	M	M	M	V
55	M	o	o	o	o	o	o
58	M	o	o	o	o	o	o
59	M	M	M	M	M	M	V
5F	M	o	o	o	o	o	o
5G	M	o	o	o	o	o	o
5K	M	M	M	V	V	V	V
5N	M	o	o	o	o	o	o
5X	M	M	M	M	M	M	V
60	M	M	M	V	V	V	V
63	M	M	M	o	o	o	o
64	M	M	M	V	V	V	V
65	M	M	M	o	o	o	o
66	M	M	M	V	V	V	V
67	M	M	M	o	o	o	o
68	M	M	M	V	V	V	V
6A	M	M	M	V	V	V	V
6C	M	M	M	V	V	V	V
6E	M	M	M	V	V	V	V
6H	M	M	M	V	V	V	V
6J	M	M	M	V	V	V	V
6N	M	M	M	V	V	V	V
6P	M	M	M	V	V	V	V
6R	M	M	M	V	V	V	V
6V	M	M	M	V	V	V	V
6W	M	M	M	o	o	o	o
6X	M	M	M	o	o	o	o
6Y	M	M	M	o	o	o	o
72	M	M	M	M	M	M	V
7A	M	M	M	M	M	M	V
7J	M	M	M	V	V	V	V
7X	M	M	M	M	M	M	V
81	M	M	M	o	o	o	o
82	M	M	M	M	M	V	V
83	M	M	M	o	o	o	o
86	M	o	M	V	V	V	V
87	M	o	M	o	o	o	o
8P	M	M	M	M	M	M	V
8R	M	M	M	M	M	M	V

* This program was terminated June 30, 2003.